Statement

of the

American Medical Association

to the

Committee on Energy and Commerce
Subcommittee on Health
U.S. House of Representatives

Re: Medicare Physician Payments: 2007 and Beyond

Presented by: Cecil B. Wilson, MD

September 28, 2006

Division of Legislative Counsel
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The American Medical Association (AMA) appreciates the opportunity to provide our views regarding "Medicare Physician Payments: 2007 and Beyond." We commend you, Chairman Barton, Mr. Deal, Mr. Dingell, and Members of the Subcommittee, for all your hard work and leadership in recognizing the fundamental need to address the fatally flawed Medicare physician payment update formula, called the sustainable growth rate, or SGR, and avert the 5% physician payment cut scheduled for 2007.

MEDICARE PHYSICIAN CUTS IN 2007 AND BEYOND

Congress Must Act Now To Avert Pay Cuts in 2007

The AMA is grateful to the Subcommittee and Congress for taking action in each of the last four years to forestall steep Medicare physician payment cuts, due to the flawed SGR physician payment formula. Yet, a crisis still looms, and, in fact, is getting worse.

Payments to physicians today are essentially the same as they were five years ago. Yet, due to the SGR, physicians now face drastic Medicare payment cuts totaling almost 40% over the next nine years. The first of these cuts is scheduled to take effect on January 1, 2007, and according to surveys by the American Medical Association (AMA) and Medical Group Management Association (MGMA), 45% of physicians and 40% of group practices will be forced to limit the number of new Medicare patients they can accept when the first cut of at least 5% goes into effect January 1, 2007. Time is running out, and Congress needs to act promptly to avert the 2007 physician pay cut by enacting a positive physician payment update that accurately reflects increases in medical practice costs, as indicated by the Medicare Economic Index (MEI).

Further, over the long-term, Congress must repeal the SGR and replace it with a system that keeps pace with increases in medical practice costs.

Congress Must Repeal the SGR and Avert Long-Term Pay Cuts Over Nine Years

As this Subcommittee focuses its attention on Medicare, we appreciate the efforts of the Full and Subcommittee to address the problems due to the SGR. In addition to the Subcommittee's efforts, there is widespread consensus that the SGR formula needs to be repealed: (i) there is bipartisan recognition in this Subcommittee and Congress that the SGR, with its projected physician pay cuts, must be replaced with a formula that reflects increases in practice costs; (ii) MedPAC has recommended that the SGR be replaced with a system that reflects increases in practice costs, with an update equivalent to the MEI for 2007; (iii) CMS Administrator McClellan has stated that the current physician payment system is "not sustainable;" and (iv) the Military Officers Association of America (MOAA) has stated that payment cuts under the SGR would significantly damage military beneficiaries' access to care under TRICARE, which will have long-term retention and readiness consequences. Further, 265 Representatives signed a letter calling on House leaders to pass legislation before they adjourn this week to provide physicians with Medicare payments that reflect increases in medical practice costs.

The AMA looks forward to working with the Subcommittee and Congress to repeal the SGR and replace it with a system that adequately keeps pace with increases in medical practice costs. We emphasize that every time action to repeal the SGR has been postponed, the cost of the next solution, whether short- or long-term, has become significantly higher and increased the risk of a complete meltdown in Medicare patients' access to care.

Beginning January 1, 2007, and extending over the next nine years, almost 200 billion dollars will be cut from payments to physicians for care provided to seniors – just as baby boomers are aging into Medicare by the millions. These cuts follow five years of congressional intervention to prevent the cuts and modest updates that have not kept up with practice cost increases, and payment rates in 2006 remain about the same as in 2001. *Data in CMS' rule on the "Five-Year Review of Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology," proposed earlier this year, indicate that Medicare now covers only two-thirds of the labor, supply and equipment costs that go into each service.*

Only physicians and other health professionals face steep cuts under this flawed payment formula. Other providers have been receiving updates that fully keep pace with their costs (and will continue to do so under current law), including Medicare Advantage plans which are already paid 11% in excess of fee-for-service costs. Physicians and other health care professionals (whose payment rates are tied to the physician fee schedule) must have payment equity with these other providers. Physicians are the foundation for our nation's health care system, and thus a stable payment environment for their services is critical.

Finally, in addition to the 2007 physician cuts due to the flawed SGR, other Medicare physician payment policy changes will take effect on January 1, 2007. These changes were discussed at length in our July testimony and relate to: (i) expiration of the MMA provision that increased payments in 58 of the 89 Medicare payment localities; and (ii) recent CMS

proposals that will change both the "work" and "practice expense" relative values, each of which are components in calculating Medicare physician payments for each individual medical service; and (iii) payment cuts in imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005.

These policy changes will have a significant impact on a large number of physicians who could experience combined pay cuts of 10% or more for many physicians' services. In fact, a recent AMA analysis indicates that if the 5% SGR cut is allowed to take effect in 2007, 13% of physicians will face cuts exceeding 10% and 32% will see cuts of 6% to 10%. We caution the Subcommittee that, taken together, all of the foregoing cuts will make it nearly impossible for most physicians to make the necessary financial investment and staff commitment to participate in quality improvement programs. The medical profession has made significant investment and progress over the past few years in the development of a system that enhances the quality of care in this country. If that momentum is to be maintained, however, Congress now must do its part by providing physicians with an adequate payment system that supports that goal.

Spending Targets Do Not Achieve their Goal of Restraining Volume Growth

Some have argued that the SGR formula is needed to restrain the growth of Medicare physicians' services. The AMA disagrees. As discussed extensively in our written testimony presented to this Subcommittee in July, spending targets, such as the SGR, cannot achieve their goal of restraining volume growth by discouraging inappropriate care.

If there is a problem with inappropriate volume growth regarding a particular type of medical service, Congress and CMS should address it through targeted actions that deal with the source of the increase.

ACCESS PROBLEMS FOR MEDICARE BENEFICIARIES UNDER THE SGR

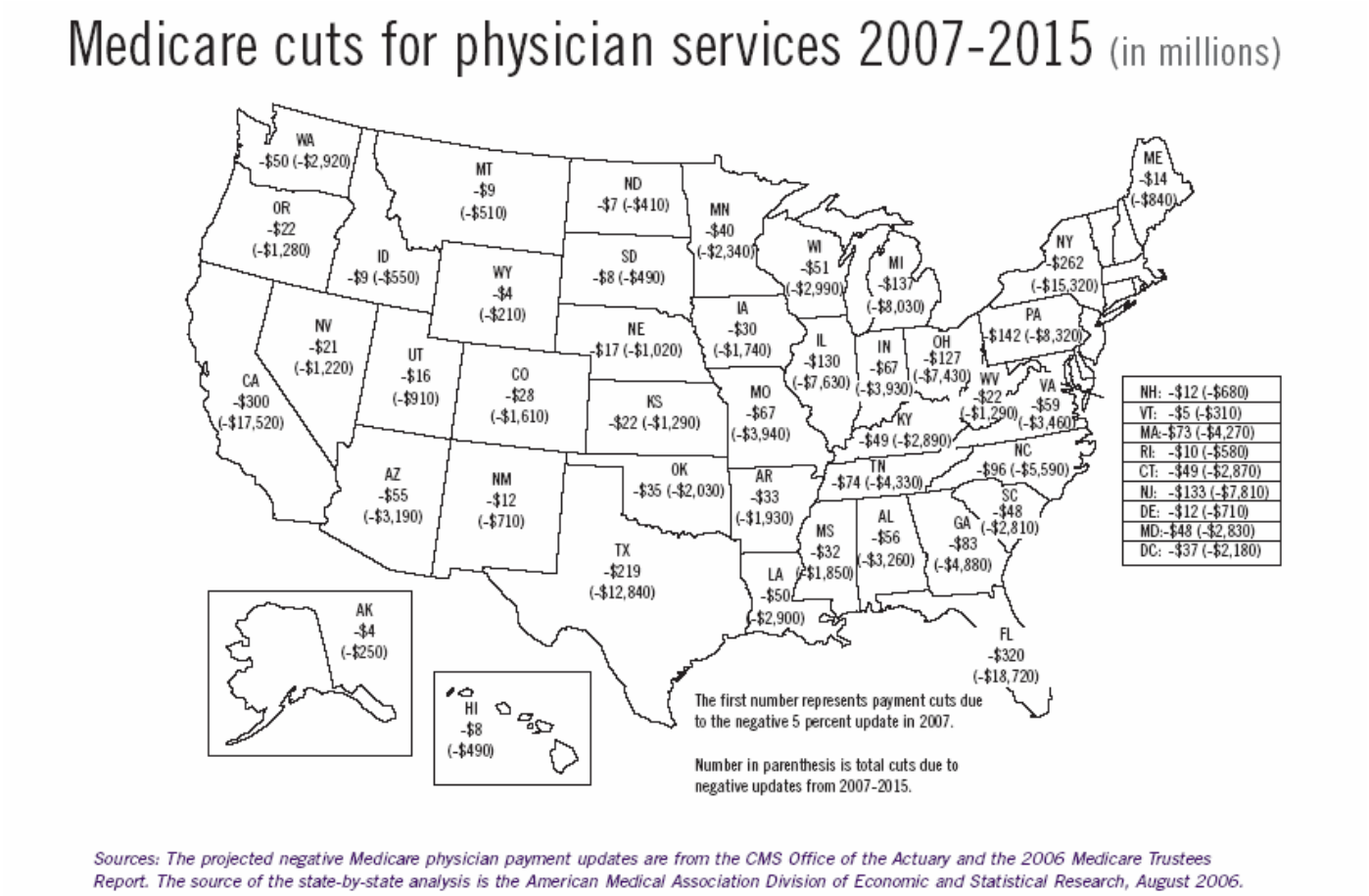
AMA Survey Shows Patient Access Will Significantly Decline if the Projected SGR Cuts Take Effect

Physicians cannot continue to absorb the draconian Medicare cuts that are projected for 2007 though 2015, especially when medical practice costs are projected to increase about 20% during this same time period, as estimated by the governments' own conservative measure. A recent AMA survey, as presented to the Subcommittee in our July testimony, confirmed that patient access will suffer as a result.

Further, a recent national poll conducted by the AMA shows that the vast majority of Americans, 86% are concerned that seniors' access to health care will be hurt if impending cuts in Medicare physician payment take effect on January 1, 2007. Further, 82% of current Medicare patients are concerned about the cuts impact on their access to health care. Baby boomers are also very concerned about the impact of the cuts on Medicare patients' access to care. A staggering 93% of baby boomers age 45-54 are concerned about the cuts impact on access to care. In just five years, the first wave of baby boomers will reach age 65, and will turn to Medicare for their health care.

IMPACT OF PROJECTED SGR CUTS ON INDIVIDUAL STATES

If Congress allows the pay cuts forecast by the Medicare Trustees to go into effect, there will be serious consequences in each state across the country. As the map below illustrates, more than 35 states will see their health care funds reduced by more than one billion dollars by the time the cuts end in 2015. Florida and California are the biggest losers, with each of these states losing close to $300 million in 2007 alone. Medicare payments in Florida would be cut by more than $18 billion from 2007-2015; California will lose more than $17 billion over the 9-year period, and Texas is not far behind with nearly $13 billion in cuts. Ohio is facing losses of more than $7 billion and Georgia will see about $5 billion in cuts.



Sources: The projected negative Medicare physician payment updates are from the CMS Office of the Actuary and the 2006 Medicare Trustees Report. The source of the state-by-state analysis is the American Medical Association Division of Economic and Statistical Research, August 2006.

Seniors cannot afford to have their access to physicians jeopardized by further reducing Medicare payment rates below the increasing costs of running medical practices. Ohio's 1.6 million Medicare beneficiaries comprise 14% of the state's population and Florida's nearly 3 million beneficiaries are 16% of its population. Even before the forecast cuts go into effect, Georgia only has 208 practicing physicians per 100,000 population and Texas has 207 practicing physicians per 100,000 population, which means both states are far below the national average of 256. Florida only has 15 practicing physicians for every 1,000 Medicare beneficiaries, 25% below the national average.

The negative effects of the cuts in the Medicare physician payment schedule are not only felt by patients, but also by the millions of employees that are involved in delivering health care services in every community. Data from the Bureau of Labor Statistics show that the physician payment cuts will affect: 80,274 employees in Georgia; 112,176 employees in Ohio; 195,288 employees in Florida; 200,469 employees in Texas; and 292,171 employees in California.

We urge the Subcommittee to avoid the serious consequences for patients that will occur if the projected SGR cuts take effect, and establish a Medicare physician payment system that helps physicians serve patients by providing payment updates that recognize continual increases in cost of providing care and incentives needed to invest in HIT and quality improvement programs.

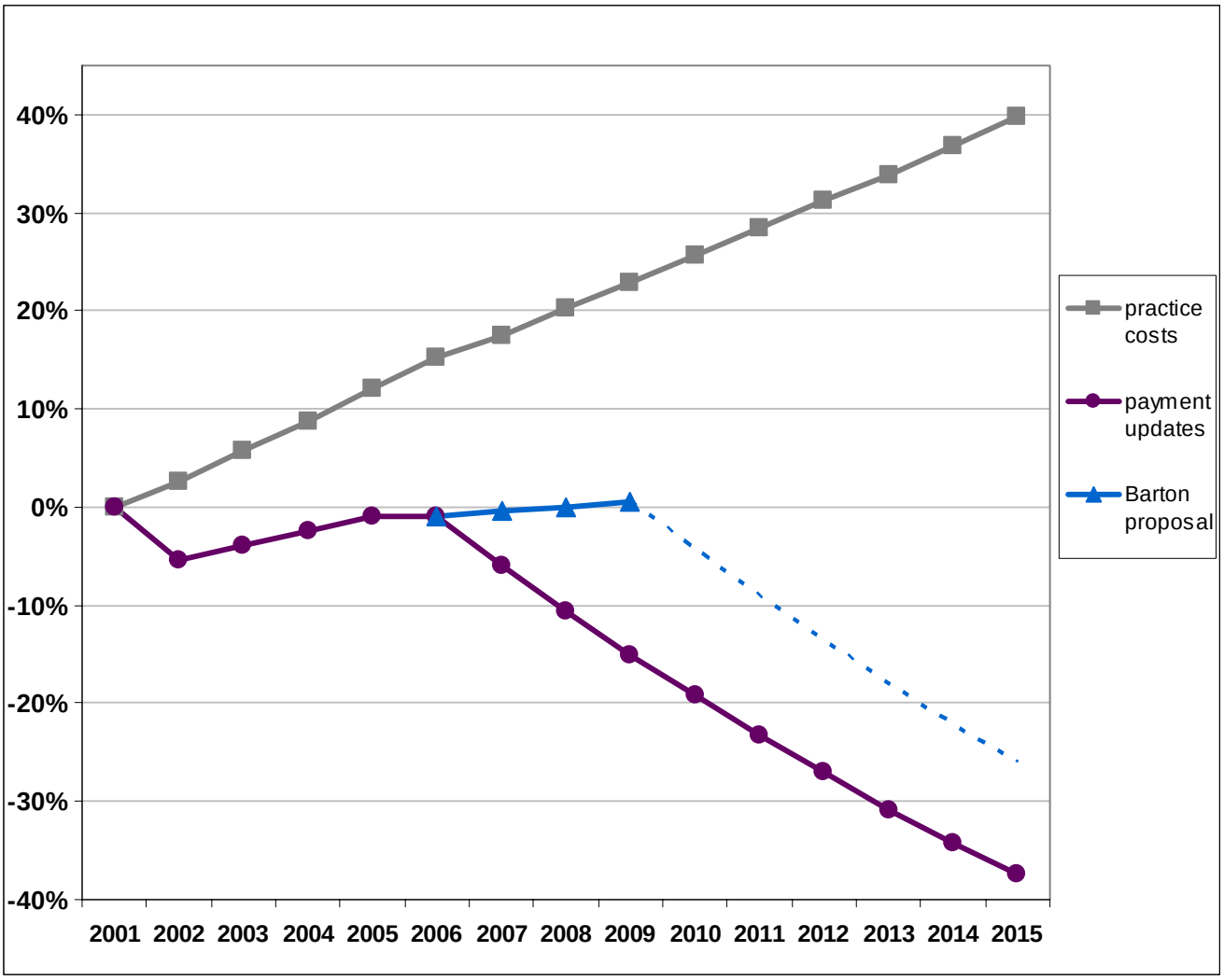
LEGISLATIVE PROPOSALS TO ADDRESS THE SGR

The AMA appreciates the efforts of Chairman Barton and Members of the Subcommittee and their staffs to address the projected physician pay cuts, caused by the flawed SGR formula. This update formula for physicians' services is broken beyond repair and needs to be replaced with a new system. Indeed, Chairman Barton and other Members of the Subcommittee have expressed the need to repeal the SGR, and legislation currently being developed by the Chairman would set the stage and allow Congress time to achieve this goal. In addition, H.R. 5866, the "Medicare Physician Payment Reform and Quality Improvement Act of 2006" introduced by Rep. Burgess (R-TX), would repeal the SGR and replace it with a payment system that is based on the MEI. Finally, Ranking Member Dingell's legislation, H.R.5916, the "Patients' Access to Physicians Act of 2006," would ensure that physicians would be paid at least the percentage increase in the MEI in 2007 and 2008.

We appreciate that each of these bills would take an important step in preserving patient access to high quality medical care by addressing the flawed SGR and implementing positive payment updates for physicians. **While the AMA supports a multi-year physician payment solution, we understand that funding for such a solution is limited. Therefore, we urge the Subcommittee to consider legislation that would provide physicians with updates over two years that reflect practice cost increases, as measured by the MEI, instead of longer-term solutions with more modest updates.** Such updates are needed to cover increases in medical practice costs, especially since updates over the last five years have fallen far behind increases in such costs. An additional payment for reporting quality data, as discussed further below, should also be provided along with these updates. Finally, we urge that any legislation providing positive physician updates be fully funded up front, and any offsets to cover the cost of these updates should not come from Medicare Part B services, as this would undermine the impact of a positive payment update.

The chart below shows the gap in Medicare payment to physicians from 2001 through 2015, as compared to increases in medical practice costs under the MEI, as well as the payment updates for 2007 through 2009 set forth in Chairman Barton's proposal.

Physician Cost Increases vs. Physician Payment Updates Under the SGR Formula: 2001-2015



We look forward to continuing our work with Congress to achieve this year our shared goals of averting the 2007 Medicare physician payment cut and adequately addressing the SGR to ensure that future physician payment updates reflect the MEI and keep pace with increases in medical practice costs.

QUALITY IMPROVEMENT LEGISLATIVE PROPOSALS

Chairman Barton's legislative proposal to address the SGR, as well as Representative Burgess' bill, H.R. 5866, would also implement a voluntary quality reporting program for physicians under Medicare. The AMA has supported the advancement of quality care since our inception and that goal remains paramount to the AMA and its physician members today.

We applaud the efforts of Chairman Barton and Representative Burgess, and respectfully urge Congress to consider the following comments as it moves forward with quality reporting legislation.

Quality Improvement Programs Cannot Co-Exist with the SGR

It is important to recognize that the current Medicare physician payment update formula cannot coexist with a payment system that rewards improvement in quality. Quality improvements are aimed largely at eliminating gaps in care and are far more likely to increase rather than decrease utilization of physician services. Specifically, quality improvements are expected to encourage more preventive care and better management of chronic conditions. While such results would reduce spending for hospital services covered by Part A of Medicare, they do so by increasing spending for the Medicare Part B physicians' services that are included in the SGR. In fact, data from the Medicare Payment Advisory Commission (MedPAC) suggest that some part of the recent growth in Medicare spending on physicians' services is associated with improved quality of care.

Increased Medicare spending on physician services, however, conflicts with the SGR, which imposes an arbitrary target on Medicare physician spending and results in physician pay cuts when physician spending exceeds the target. Thus, additional and appropriate physician services encouraged under a quality reporting program will result in more physician pay cuts.

Further, pay-for-performance programs depend on greater physician adoption of information technology at great cost to physician practices. A study by Robert H. Miller and others found that initial electronic health record costs were approximately $44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about $8,500 per FTE provider per year. (*Health Affairs*, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from $37,056 to $63,600 per FTE provider. Without positive payment updates, it will be difficult for physicians to make these HIT investments. In fact, a 2006 AMA survey shows that if the projected nine years of cuts take effect, 73% of responding physicians will defer purchase of new medical equipment, and 65% will defer purchase of new information technology. Even with just one year of cuts, half of the physicians surveyed will defer purchases of information technology.

We urge the Subcommittee to ensure that any quality reporting program is premised on: (i) positive and adequate physician payment updates that reflect increases in medical practice costs; and (ii) additional payments that fully offset physicians' administrative costs in reporting quality data and thus provide an incentive to report.

Quality Improvement Legislation Should Establish a Specific Process for Developing Measures for Which Physicians Report Data

Chairman Barton's proposal provides a framework with certain options to allow physicians to report quality information under the Medicare program. To enhance this framework even further, we encourage certain refinements of the proposal.

We urge that the Chairman's proposal establish a specific process for designating the measures for which physicians are to report data. The legislation should also specifically provide that under this process:

- **Clinical and structural measures would be developed by the physician medical specialty societies through the Physician Consortium on Performance Improvement (the Consortium).**
- **Measures must be: (i) evidence-based, and developed collaboratively across physician specialties; (ii) consistent, valid, practicable, and not overly burdensome to collect; and (iii) relevant to physicians and other practitioners, and Medicare beneficiaries.**
- **The Secretary would adopt and publish the Consortium measures for the Medicare program and could not make modifications without the Consortium's consent.**
- **Solo physicians or group practices (as well as non-physicians who provide services under the physician fee schedule) would report data to CMS on the measures chosen by the physician or group from among those adopted and published by CMS.**
- **Physicians would provide the Secretary with an attestation that the data will be submitted as required for reporting purposes.**

Setting forth this overall process in the legislation would ensure that it builds on existing structures that are in place to facilitate quality improvement programs and that have already completed significant work in this regard. As the AMA promised Congress last year, the Consortium has already developed about 100 quality measures and an additional nearly 70 are expected by the end of the year. Further, since the Chairman's proposal would provide a "ramp-up" period in 2007, the Consortium could use that time to develop measures similar to, but more cross-cutting than, those now contained in the proposal.

The AMA convened the Consortium in 2000 for the development of performance measurements and related quality activities. The Consortium is currently comprised of over 100 national medical specialty and state medical societies; the Council of Medical Specialty Societies, American Board of Medical Specialties and its member-boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality; and Centers for Medicare & Medicaid Services. The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance (NCQA) are also liaison members.

The Consortium is a physician-consensus-building organization and has become the leading physician-sponsored initiative in the country in developing physician-level performance measures. CMS is now using the measures developed by the Consortium in its large group practice demonstration project on pay-for-performance, and plans to use them in demonstration projects authorized by the MMA. Further, the Consortium has been working with Congress to improve quality measurement efforts, as well as with CMS to ensure that the measures and reporting mechanisms that could form the basis of a voluntary reporting program for physicians reflect the collaborative work already undertaken by the AMA, CMS, and the rest of the physician community.

A process that requires measures to be developed by physicians through the Consortium also ensures that measures are as cross-cutting as possible, thus expanding on the reporting options contained in the Chairman Barton proposal. This would provide all physician specialties with the opportunity to participate in any voluntary reporting program.

A Physician Quality Improvement Program Should Be Voluntary, with Additional Payments to Offset Physicians' Administrative Costs in Reporting Data

The AMA appreciates that Chairman Barton's proposal would implement a voluntary physician reporting program and provide additional bonus payments for meeting the reporting requirements. A voluntary program is especially critical since physician specialties are at varying levels of readiness with respect to the development of quality measures. Further, since the time dedicated to meeting the reporting requirements is an additional financial and paperwork burden on physicians, we also encourage Congress to provide bonus payments that fully offset physicians' administrative costs in meeting these. Without adequate offsets, the program simply becomes another unfunded mandate for physicians, which would undermine any incentive to participate in the program.

The Institute of Medicine, in its recently-released report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, emphasized that a voluntary approach for physicians should be pursued initially, relying on financial incentives sufficient to ensure broad participation and recognizing that the initial set of measures and the pace of expansion of measure sets will need to be sensitive to the operational challenges faced by providers in small practice settings. The report also highlights the need for investment dollars to create adequate resources to affect change due to the unique challenges of physician payment relating to the SGR, and further indicates that access could suffer if additional funds are not used to initiate a quality improvement program for physicians.

Medical Home Demonstration

The AMA supports the concept of managing chronically ill Medicare patients under a "medical home" demonstration project, as is currently included Chairman Barton's proposal. We urge that any such demonstration project apply to all physicians, not just primary care physicians. Many other medical specialty physicians manage patients with chronic conditions, including such physicians as oncologists and cardiologists, and thus these other physicians should be permitted to participate in the medical home demonstration as well.

Under the Barton proposal, the Secretary would consider care management fees to the personal physician that covers the physician work that falls outside the face-to-face visit as a method of reimbursement under the medical home demonstration project. We note that there are existing CPT codes for care management. Thus, new codes for these services may not be needed.

Utilization Review

We appreciate that the utilization review provisions in Chairman Barton's proposal would direct that such activities be carried out at the local level, where there is more ability to appropriately evaluate individual physician claims data and determine whether any changes in treatment protocol are necessary.

The AMA encourages, however, more specificity in the utilization review provisions to: (i) ensure that such programs are educational and not punitive — these programs should be for the purpose of providing physicians with utilization data to determine whether any changes to improve quality are needed in the treatment process; (ii) ensure that such programs protect the privacy of the claims data and do not allow such data to be discoverable in any legal proceeding against a physician; and (iii) allow aggregate data to be shared with appropriate medical specialty organizations.

The AMA appreciates the opportunity to provide our views to the Subcommittee on these critical matters. We look forward to working with the Subcommittee and Congress to pass legislation immediately that preserves patient access, averts the 2007 physician pay cut, and provides a positive payment update that reflects medical practice cost increases.